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ABSTRACT

School counselors are often consultants for parents and teachers on problems that children and adolescents face. Attention deficit disorder (ADD) is one such problem. It is frequently misunderstood, presenting a challenge for parents and teachers alike. The counselor is a resource for initial identification and interventions at home and in the classroom. The counselor must have at least a working knowledge of typical symptoms and likely responses to environmental demands in order to be an effective resource on attention deficit. This digest reviews the etiology of ADD, symptoms and diagnosis, treatment options, and interventions including counseling, consultation, and support. (Contains 11 references.) (GCP)

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ADD and ADHD: An Overview for School Counselors

ERIC/CASS Digest

by

Deanna S. Pledge

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ERIC CASS DIGEST

ADD and ADHD: An Overview for School Counselors

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Introduction

School counselors are often consultants for parents and teachers on problems that children and adolescents face. Attention deficit is one such problem. It is frequently misunderstood, presenting a challenge for parents and teachers alike. The counselor is a resource for initial identification and interventions at home and in the classroom. The counselor must have at least a working knowledge of typical symptoms and likely responses to environmental demands in order to be an effective resource on attention deficit.

Etiology

Attention Deficit Disorder without Hyperactivity (ADD) or with Hyperactivity (ADHD) continues to be a misunderstood diagnosis by many. Some parents and teachers still hold a perception that the label simply provides an excuse for disruptive behavior; however, studies continue to support a biochemical or organic basis to the disorder.

Presentation of symptoms can be affected by family interactions, school expectations, and other demands placed on the individual child. Part of the reason that attention deficit is usually diagnosed in school age children (e.g., first to third grade) is attributable to the demands placed on the child when beginning school (American Psychiatric Association [APA], 2000). The structure at school differs from that in the home or preschool environment.

Typical predisposing factors within the individual, as well as in the family history, are being identified in the literature (Chi and Hinshaw, 2002). For example, a history of alcoholism, smoking, or depression in parents can be predisposing factors (Mick, Biederman, Faroane, Sayer, and Kleinman, 2002). Certain physiological markers, such as frequent early ear infections (Combs, 2002), have also been associated with the presentation of attention deficit. Physical complications can be a factor in the development of language and reading disabilities that are associated with attention deficit for between 45% and 60% of those diagnosed (Lloyd, Hallahan, Kauffman, and Keller, 1998).

Attention Deficit Disorder presents in a slightly different way for each individual, partially due to the factors noted above. Although there is a cluster of symptoms usually associated with the disorder, the individual presentation can be just as varied as the predisposing factors.

Symptoms and Diagnosis

Diagnosis in children and adults is usually made by history, self-report, and observation from significant others in the person's life. Central to diagnosis in children are the symptoms in the general areas of inattention, impulsivity, and hyperactivity (APA, 2000). In adults, the most prominent symptom is inattention (Stern, Garg, and Stern, 2002).

Symptoms of attention deficit can be mimicked by emotional disorders, e.g., reaction to abuse, depression or anxiety (APA, 2000). If therapy is not successful in addressing underlying emotional concerns, medication may be used with positive results just as in the case of more classic symptoms of ADHD. In those cases where early abuse or neglect has been instrumental in affecting the neurology of the individual, the actual outcome, and thus treatment, may not differ significantly from other cases of ADHD. Difficulty sleeping is often seen with attention deficit, particularly for those with hyperactivity (Stein, Pat-Horenczyk, Blank, Dagan, Barak, and Gumpel, 2002). Sleep problems can also be exacerbated by medication use.

Other disorders may co-occur with Attention Deficit Disorder. Those commonly observed include: Tourette's, Obsessive-Compulsive Disorder, Depression, Autism, Oppositional Defiant Disorder (ODD), or Conduct Disorder (CD) (Burns and Walsh, 2002). The relationship between ADHD, ODD, and CD is often presented on a continuum or as a progressive relationship. Symptoms of ADHD often present initially, followed by ODD, and ultimately CD for a small percentage of those with initial attention problems. Individual characteristics, family factors, and life experiences all interact to push some individuals through this continuum to more serious behavioral concerns. The comorbidity of other disorders or symptoms often makes successful treatment more difficult.

Other features of ADHD include differences in level of executive functioning between those who present with hyperactivity and those who do not (Klorman, Hazel-Fernandez, Shaywitz, Fletcher, Marchione, Holahan, Stuebing, and Shaywitz, 1999). Deficits in executive functioning are associated with greater hyperactivity and impulsivity. These differences in executive functioning include an inability to self-monitor and self-control.

Prevalence estimates for ADHD and ADD are between 3 to 7% of school age children (American Psychiatric Association, 2000).

Treatment Options

Effective treatment usually combines medication and therapy, including behavioral interventions aimed at increasing structure at home and school. Parents and teachers are active participants in successful treatment efforts. Stimulants are the most commonly used medications, with some use of anti-depressants, for co-morbid conditions of depression and anxiety (Shatin and Drinkard, 2002). Other interventions include parent training and family therapy, individual therapy, support groups, and social skills training. Providing structure for these individuals, and helping children learn to provide structure for themselves, are at the core of successful interventions (Shapiro, DuPaul and Bradley-Klug, 1998).

Although medication is often part of a successful treatment approach, school personnel are usually not directly involved in recommending a prescription. Diagnoses and prescriptions can only be provided by the family physician, pediatrician, or psychiatrist. Even the process of referral can expose a school to liability for financial responsibility, so the counselor needs to be aware of the manner in which any conversation about medication or referral takes place.

Interventions: Counseling, Consultation, and Support

The counselor's role in enhancing the academic performance of students with ADD or ADHD often involves consultation with teachers around classroom interventions, as well as providing support and education to parents. In addition to basic behavioral interventions, coping skills, social skills, and self-monitoring skills are important tools that can be reviewed through various modalities, including individual counseling, group sessions, or classroom guidance modules. Providing workshops in the evening with separate sessions for parents and children can be a resource welcomed by parents. Such efforts may be jointly offered with community support groups.

Parents often need information about appropriate expectations for behavior and school work, positive parenting techniques, and support groups at the school or in the community, such as CHADD (a support group for children and adults with attention deficit disorder). For example, a counseling newsletter to parents can provide descriptions of ADD, such as the fact that disruptive behaviors observed at school may not be observed at home, or that behavior can be inconsistent – at times under the child's control, and impulsive at others. Information and support can help parents in making the decision to seek an evaluation.

Typical challenges for students with ADD or ADHD include: 1) organizational problems; 2) problems with transitions; 3) acting as if rules don't apply to them; 4) adopting a negative attitude out of frustration in academic tasks, social interactions, or as a defense against low self esteem; 5) experiencing isolation or exclusion from peers; 6) poor grades as a result of rushing through assignments, incomplete work, or distractibility in class; 7) impulsive behavior; 8) difficulty sustaining attention; 9) different learning styles; or 10) disruption of sleep or appetite, as a result of ADD or medication. These students often describe feeling bored at school, and may appear oppositional (APA, 2000). Motivation around academic tasks or conforming to rules can be a challenge for these students.

A simple intervention that has proven successful includes "chunking" or organizing assignments into smaller sections. This makes successful completion a more likely outcome, and if applied to in-class assignments, allows the student a legitimate reason to get up and walk to the teacher's desk. Even such a small amount of movement can help discharge energy that is so critical for these students. It is for this reason that a common consequence for not completing homework (i.e., losing recess) is actually counter-productive with overactive children.

It is also important to remember the lack of self-monitoring ability as being central for many of these individuals. Teachers and parents can help children and adolescents develop this skill. Mechanisms to increase self-awareness include external monitoring systems such as checklists in the classroom. Additionally, the teacher can provide verbal cues such as asking the class to, "Stop and check – where is your mind?" Or the teacher can use physical monitoring cues for particular students, e.g., a simple tap on the shoulder to help them self-monitor. These cues are general enough to ensure that students don't feel ostracized by their use.

Prognosis

Symptoms of attention deficit continue throughout adulthood, although symptoms of hyperactivity generally do not. Recent estimates as high as 50% have been made regarding the continuation of symptoms into adulthood (Stern, Garg and Stern, 2002). It is noted that the gender ratio in adulthood (approximately twice as frequent for males) is more equal than in childhood (estimates ranging from 6 to 10 males for every 1 to 3 females; APA, 2000).

Resources

Children and Adults with Attention Deficit Disorder (CHADD) CHADD website: http://www.chadd.org/
CHADD National Call Center 1-800-233-4050

Attention Deficit Disorder Association Website: www.add.org

American Academy of Child & Adolescent Psychiatry Website: http://www.aacap.org/

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